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Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVN4234AGC				B. WING		01/04/2011		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
CAINT DAILL HOME CADE 2			4900 KOEN RENO, NV	KOENIG ROAD NV 89506				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
Y 000	Initial Comments		Y 000					
	by the Health Division prohibiting any crimin actions or other claim available to any party state, or local laws. This Statement of Dear result of an annual conducted in your fact Licensure survey was of NRS 449.150, Pow The facility is licensed for Group beds for eleand/or persons with not and Category II residue of the survey was were reviewed and two	clusions of any investign shall not be construed all or civil investigations as for relief that may be under applicable feder ficiencies was generated State Licensure survey cility on 1/4/11. This State Conducted by the authors of the Health Division of the Health Division of the Health Division of the Residential Faderly and disabled personental retardation, Cated dents. The census at the seight. Eight resident for employee files were arged resident file was	I as					
	The facility received a							
	The following deficien	ncies were identified:						
Y 103 SS=E	449.200(1)(d) Person Tuberculosis	nnel File - NAC 441A /		Y 103				
	a separate personnel member of the staff or	se provided in subsection file must be kept for ea of a facility and must inc tates required pursuant of for the employee.	ach lude:					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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AND DIAM OF CODDECTION		` '	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NVN4234AGC				B. WING		01/04/2011		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	1		
SAINT PA	UL HOME CARE 2		4900 KOEN RENO, NV 8					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
Y 103	This Regulation is not met as evidenced by: Based on record review on 1/4/11, the facility failed to ensure 1 of 2 employees had a pre-employment physical examination (Employee #1). Severity: 2 Scope: 2			Y 103				
Y 178 SS=F	Y 178 SS=F 449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall			Y 178				
	ensure that the premi	ses are clean and that andscaping of the facili	the					
	Based on observation to ensure the premise maintained. (No covidasement hall area. L dryer.)	ng bases were provided int was observed behir	failed d in a					
	Severity: 2 Scope:							
Y 936 SS=D	449.2749(1)(e) Resid Tuberculosis	ent file-NRS 441A		Y 936				
	resident of a residenti	et be maintained for each al facility and retained permanently leaves the	for at					

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NVN4234AGC NAME OF PROVIDER OR SUPPLIER SAINT PAUL HOME CARE 2 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y 936 Continued From page 2 facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.	AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
SAINT PAUL HOME CARE 2 STREET ADDRESS, CITY, STATE, ZIP CODE 4900 KOENIG ROAD RENO, NV 89506 (X4) ID PREFIX TAG COntinued From page 2 facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. STREET ADDRESS, CITY, STATE, ZIP CODE 4900 KOENIG ROAD RENO, NV 89506 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DATE Y 936 Y 936 Y 936 Y 936 This Regulation is not met as evidenced by:				01/04/2011					
SAINT PAUL HOME CARE 2 RENO, NV 89506	l .			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Y 936 Continued From page 2 facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by:	SAINT PA	UL HOME CARE 2							
facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
Based on record review on 1/4/11, the facility failed to ensure 1 of 8 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #1). Severity: 2 Scope: 2	Y 936	facility. The file must that is resistant to fire unauthorized use. T records, letters, asse information and any the resident, includin (e) Evidence of compensate the example of the pursuant the This Regulation is not be assed on record revifailed to ensure 1 of NAC 441A.380 regard (Resident #1).	t be kept locked in a plate and is protected again he file must contain all essments, medical other information related without limitation: oliance with the provisions and the regulations ereto. The provided has a suidenced by the work of 1/4/11, the facilities are sidents complied with the provided his presidents complied with the provided his protection and the provided his provided his protection and the provided his protection and the provided his protection and the provided his provided h	d to ns of y th	Y 936				